DEPARTMENT OF SAFETY
DIVISION OF FIRE STANDARDS & TRAINING
BUREAU OF EMERGENCY MEDICAL SERVICES
NH EMS TRANSPORTING UNIT APPLICATION
PLEASE PRINT (BLACK INK) OR TYPE

UNIT LICENSE NUMBER:_____

LEGAL NAME OF UNIT

_____

BUSINESS STREET ADDRESS

_____
STREET CITY STATE ZIP CODE

BUSINESS PHONE (_____)_____ EMERGENCY PHONE (____)_____

MAILING ADDRESS _____
STREET/POB CITY STATE ZIP CODE

HEAD OF UNIT _____ TITLE _____ DAY PHONE _____

EMAIL ADDRESS _____ FAX #: _____

ALTERNATE CONTACT _____ DAY PHONE _____

EMAIL _____ FAX _____

MEDICAL RESOURCE HOSPITAL _____

MEDICAL DIRECTOR:_____ COPY OF MRH AGREEMENT ATTACHED_____

OPERATIONS

(1) ___ Commercial (2) ___ Funeral Director (3) ___ Hospital Based (4) ___ [Paid] Municipal FD
(5) ___ [Paid] Municipal Police (6) ___ Vol. FD (7) ___ Volunteer (8) ___ Other [Specify] _____

VEHICLE SHELTER

Type of shelter: Closed Garage:_____ Type of interior heat_____ or Heated Garage:_____

Street Location _____

NOTE: PLASTIC, CANVAS OR OTHER TARPAULIN TYPE COVER, WHICH ARE DRAPED OVER THE VEHICLE ARE NOT CONSIDERED SUFFICIENT VEHICLE SHELTER

COMMUNICATIONS

NAME OF DISPATCH CENTER: _____ BUSINESS PHONE #: _____

ADDRESS:_____

DISPATCH RADIO FREQUENCY: _____

OPERATIONS RADIO FREQUENCY [if appropriate]: _____

NAME OF INSURANCE COMPANY _____

- **THE FEE FOR A UNIT LICENSE IS $100.00. PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO THE "STATE OF NH". PURSUANT TO RSA 153-A:15, THERE SHALL BE NO LICENSING FEE CHARGED TO NON-PROFIT/VOLUNTEER EMS UNITS OR MUNICIPALITIES.**
- **A COPY OF CURRENT GENERAL & PROFESSIONAL LIABILITY INSURANCE IS REQUIRED (Saf-C 5903.03(2))**

STATEMENTS OF CERTIFICATION

FCC AGREEMENT

I, _____, an official of _____
(Unit Name)
hereby agree to abide by the rules & regulations of the Federal Communications Commission and all the rules & regulations & procedures promulgated by the chief of the Bureau of Emergency Medical Services as they pertain to the use of the following radio frequencies: 155.340 MHz & 155.175 MHz and further agree that: A. the licensee shall have access to the grantee's communications maintenance records

B. all grantees communications maintenance records be retained for one year

C. all transmissions will be of an official nature

D. the Bureau of EMS has the right to revoke this agreement immediately upon receipt of evidence regarding misuse of these frequencies by the grantee or any of his employees.

(Head of Unit/or Altenate) Signature: _____

NOTICE TO ALL APPLICANTS

Authority: NH RSA 153-A:10 and Administrative Rules Saf-C 5902, 5903, 5904

1. Organizations providing emergency medical services ambulance transportation must be currently licensed with the NH Bureau of Emergency Medical Services as a "Transporting EMS Unit".

2. The Unit must have a designated "Medical Resource Hospital" as indicated on the Unit application form with a copy on file at the Bureau of EMS.

3. In order to be licensed, a Transporting Unit must show documentation of ownership of an ambulance vehicle.

4. Provider personnel affiliated with the Unit must maintain appropriate licensure with the NH Bureau of EMS. Units may have personnel at First Responder through Paramedic levels. An "ALS Agreement" between the Unit and the Medical Resource Hospital is necessary for affiliated EMT-Intermediate or Paramedic personnel to practice at the advanced level. **A legible photocopy of the "ALS Agreement" must be on file with the NH Bureau of EMS.**

5. NH EMS Units are licensed on a 2-year cycle. Unit relicensure is required prior to expiration of the current licensing period.

6. During the licensure period the following requirements must be maintained:
   * submit current roster of licensed Unit personnel including legal name and current NH EMS Provider #
   * as personnel additions or deletions occur, submit above info to the Bureau.
   * changes in Head of Unit/Designee; Unit address; contact numbers; & ambulance vehicles need to be submitted in writing to the Bureau of EMS.

7. The Unit is responsible for Recordkeeping and reporting. **This includes documenting on either the Bureau supplied or Bureau-approved Patient Care Record Form all incidents where the Unit was requested, dispatched or canceled and whether patient contact/care was rendered or refused. A Patient Care Record will be completed for each patient.** (PCR's are available at no charge from the Bureau). Legible photocopies of all PCR's will be forwarded to the Bureau of EMS by the 15th of each month for data collection. (The Bureau of EMS provides prepaid mailer envelopes).

8. The unit shall operate in accordance with all applicable local ordinances regarding EMS.

ACKNOWLEDGMENT

I, THE UNDERSIGNED, ATTEST THAT I AM DULY AUTHORIZED TO COMPLETE AND SIGN THIS APPLICATION; THAT I HAVE READ THIS APPLICATION IN ITS ENTIRETY; AND THAT THE INFORMATION CONTAINED HEREIN IS ACCURATE AND TRUE. SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY ON

DATE _____ **SIGNATURE** _____

MAIL COMPLETED APPLICATION TO:
NH BUREAU OF EMS

STATEMENTS OF CERTIFICATION

33 HAZEN DRIVE
CONCORD NH 03305
(603) 271-7048